EDUCATION LEADERSHIP CONFERENCE 2017

2\textsuperscript{nd} annual regional consortium session:
Envisioning enhanced academic-clinical partnerships

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HOSTED BY THE NATIONAL CONSORTIUM OF CLINICAL EDUCATORS

Facilitators and Board members assisting today’s presentation

- Christine McCallum, PT, PhD
- Tawna Wilkinson, PT, DPT, PCS
- Michael Geelhoed, PT, DPT, MTC, OCS
- Kathleen Manella, PT, PhD
- Chrissy Ropp, PT, DPT, GCS, CEEAA
- Joan Drevins, PT, DPT, MS, CCS
- Vicki LaFay, PT, DPT, CSCS, CEEAA
- Robin Galley, PT, DPT, OCS
- Lori Nolan Gusman, PT, DPT, MS
- Julie Bibo, PT
- Marcia Himes, PT, DPT
- Dawn Hicks PT, DPT
REGISTRATION AND NAME TAG CODING
Sign in, find your name tag and add stickers/ribbons to code

- **STAR STICKER COLOR CODE** for your primary clinical role
  - CCCE = GREEN
  - CI = YELLOW
  - “Clinical” administrator (owner, manager, employer) = RED
  - DCE/ACCE/Asst DCE) = PURPLE
  - “Academic” administrator (program director) = BLUE

- **RIBBON COLOR CODE** for your geographic location
<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of participants</td>
<td>54</td>
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<tr>
<td>Number of regional consortia represented</td>
<td>22</td>
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<tr>
<td>Number of DCE/ACCE/Assistant DCE</td>
<td>34</td>
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<td>Number of consortium officers</td>
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<td>Number of CCCEs</td>
<td>12</td>
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<td>Number of CIs</td>
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<tr>
<td>Number of clinic managers/employers</td>
<td>8</td>
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<tr>
<td>Number of PT program administrators</td>
<td>5</td>
</tr>
<tr>
<td>Number of practice owners</td>
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GEOGRAPHIC REPRESENTATION

RURAL - URBAN DISTRIBUTION (RUCA CODES)
- Urban
- Large Rural City/Town
- Small and Isolated Small Rural Town

- 90% Urban
- 6% Large Rural City/Town
- 4% Small and Isolated Small Rural Town
INTRODUCTIONS - STAR FINDING
For both connect with someone with a different color ribbon

- Spend 3 minutes finding and speaking with someone with the same colored star that you have
- Find out what they feel is most rewarding about their current role
- Spend 3 minutes finding and speaking with someone that has a star color different than yours
- Find out how they would like to see interaction grow between their role and yours
SESSION INTRODUCTION

- Last year’s regional consortia session
  - Information gathering
  - Initial networking
  - Resources tab - [NCCE website](#)

- This year’s desire
  - Action planning around the topic of the academic-clinical partnership
  - Jump start through pre-course survey!
SESSION OBJECTIVES
By the end of this session, participants will be able to:

- Share information from other consortia/regions with colleagues and stakeholders in their consortium
- Discuss capacity and variation from the perspective of different clinical education stakeholder’s perspectives
- Articulate at least one action plan related to enhancing academic-clinical partnerships in their region
- Agree to discuss this with their regional consortia to determine implementation feasibility
SESSION RULES

- Network, share information
- Stay focused
- Don’t get caught in the weeds
- Focus discussions on usual and consistent trends not isolated instances
- No side conversations
- Everyone participates - no one dominates
- Take notes and brainstorm throughout the session
STRUCTURE OF ACADEMIC-CLINICAL PARTNERSHIPS WITHIN REGIONAL CONSORTIA

Pre-meeting survey results
Perception of Academic-Clinical Partnerships

Strength of current regional partnerships

How would you rate your regional consortium's partnerships as they exist today?

22 responses

- 40.9%: Engaged academic and clinical partners across the region
- 31.8%: Strong academic-clinical partnerships by program but needs improvement across the region
- 13.6%: Programmatic relationships vary in strength AND regional partnerships across the region need improvement.
- We have a very strong academic presence but continue to encourage a stronger clinical presence.
- Most programs have relationships with the same clinical partners. We all use the same sites.
- Strong academic-clinical partnerships by program but needs improvement across the region.
PERCEPTION OF ACADEMIC-CLINICAL PARTNERSHIPS

Plans to enhance regional partnerships

Does your regional consortium have plans/goals to increase or enhance academic-clinical partnership?

22 responses

- Yes: 63.6%
- No-but we have discussed this issue: 31.8%
- No, we have not discussed this issue:
STAKEHOLDER REPRESENTATION IN REGIONAL CONSORTIA

Does your regional consortium structure formally include: (mark all that apply)

22 responses

- Academic clinic... 22 (100%)
- Clinical educator... 15 (68.2%)
- Clinical admin... 4 (18.2%)
- Academic admin... 2 (9.1%)
- Students... 0 (0%)
- Others?... 0 (0%)
STAKEHOLDER REPRESENTATION
Comment themes

- Clinical educators and administrators have limited role
  - Limited in number ("2 CCCEs who serve as elected clinician members")
  - Limited in capacity ("considered consultant members")
- Just beginning to include clinical educators
  - "recently updated our bylaws to include…"
- Open to all
  - "academic clinical educators are paying members but all local CCCEs and CIs are welcome to have free membership"
  - "open to all but not all of the above roles are members"
ROLES BY STAKEHOLDER

Academic Admin
Clinical Admin
CCCE/CI
DCE/ACE

Voting, Develop P&P, Advisory Role, Event Planning
Providing Con Ed, Attending Con Ed, Attend M&Gs, Placement Collab
VARIATION IN EDUCATION AND PRACTICE

Unwarranted variation discussion
Results from survey
Break-out discussions
Tara Jo Manal, PT, DPT, FAPTA gave delivery of the 22nd John H. P. Maley Lecture at NEXT 2017 titled *Variation in Care is the Profession’s Greatest Challenge.*

https://www.youtube.com/watch?v=XeuPh3XrHc4&feature=youtu.be
DEFINING UNWARRANTED VARIATION

“Unwarranted variation doesn’t mean we have to be the same. It means that, if we are variable, that the variations we have don’t actually impact the outcomes. So, you and I could rehab somebody very differently, but we get to the same point, with the same cost, and same investment of resources. Then that is not unwarranted variation. We are at the same place. We are the same. It is unwarranted when it is outside of what that standard would be.”

Tara Jo Manal, PT, DPT, FAPTA
PERCEPTIONS OF VARIATION IN PT EDUCATION/CLINICAL EDUCATION

Has your regional consortium worked collaboratively on any projects to try to reduce the variation in PT education in your region?

22 responses

- Yes: 45.5%
- No: 18.2%
- No, but we have discussed this: 36.4%

Does your regional consortium perceive that there is variation in PT education/clinical education curricula in your region?

22 responses

- Yes-wide variation: 72.7%
- Yes-to a low or moderate degree: 18.2%
- No: 9.1%
- Unable to assess: 0%
PERCEPTIONS OF VARIATION IN PRACTICE

Does your regional consortium perceive that there is variation in clinical practice in your region?
22 responses

- Yes-wide variation: 53.6%
- Yes to a low or moderate degree: 13.6%
- No: 13.6%
- Unable to assess: 9.1%

Has your regional consortium worked collaboratively on any projects to try to reduce the variation in PT clinical practice in your region?
22 responses

- Yes: 59.1%
- No: 18.2%
- No, but we have discussed this: 22.7%
PERCEPTIONS OF VARIATION IN EDUCATION

PERCEPTIONS OF VARIATION IN PRACTICE

[Map of the United States showing variation in perceptions of variation in education and practice, with states color-coded to indicate levels of variation: wide variation, low to moderate variation, unable to assess, mixed, no variation.]
**THEMES FROM COMMENTS ON VARIATION**

- Collaborations to decrease variation include:
  - Standardized policies (ie: attendance, professional expectations, etc.)
  - Standardized procedures (ie: March mailer)
  - Provide education/workshops/developed modules to reduce variation in clinical education practice
  - Use same performance assessment instrument

- Having discussions regarding:
  - Variations in quality
  - Definition of variation - “good vs bad” variation
  - Difficulty influencing another site/institution’s practices
How can we relate this to both physical therapy education/clinical education and clinical practice?

Variation that offers opportunities for improvement ......
Let's not focus on the negatives, but the positive ways in which we can improve in both physical therapy education/clinical education and clinical practice for the best patient/student experiences and outcomes.
WHAT TYPE OF VARIATION IS HAPPENING IN PHYSICAL THERAPY EDUCATION/CLINICAL EDUCATION THAT IS PROBLEMATIC/UNWARRANTED?

- Small group discussion:
  - Academic Administrator, ACCE, DCE
  - Clinical Administrator, CCCE, CI
- Discuss and create top 3 problematic/unwarranted areas of concern
WHAT TYPE OF VARIATION IS HAPPENING IN CLINICAL PRACTICE THAT IS PROBLEMATIC/UNWARRANTED?

- Small group discussion:
  - Academic Administrator, ACCE, DCE
  - Clinical Administrator, CCCE, CI

- Discuss and create top 3 problematic/unwarranted areas of concern
FACILITATORS SWITCH SIDES OF ROOM

- “Academic” review/discuss information from “Clinical”
- “Clinical” review/discuss information from “Academic”
- Consider things like:
  - What can and cannot be changed
  - What resources are needed/available to address these items
- Rule out any items that are unreasonable and/or beyond our control!
TOP VARIATIONS IN EDUCATION/CLINICAL EDUCATION FROM ROUNDTABLE DISCUSSIONS

- Clinicians: readiness of CI, quality of CI, assessment of students
- Clinical education curriculum: level of preparation, length/timing of experience, requirements for types of experiences, number of students being placed
- Payment for clinical education
- Onboarding variations
- Clinical affiliation agreement differences
- Terminology
TOP VARIATIONS IN PRACTICE FROM ROUNDTABLE DISCUSSIONS

- Clinic/clinicians: EBP, CEUs, tx/interventions/philosophy, CI credentials, CI participation, onboarding requirements
- Workflow: supervision, productivity, documentation, billing, culture, role of PT, direct access
- Quality of student: readiness, performance, assessment, site selection, school requirements, affective behaviors
MIXED GROUP BREAKOUT

Variations in education

- Clinicians: readiness of CI, quality of CI, assessment of students
- Clin ed curriculum: level of preparation, length/timing of experience, requirements for types of experiences, number of students being placed
- Payment for clinical education
- Onboarding variations
- Clinical affiliation agreement differences
- Terminology

Variations in practice

- Clinic/clinicians: EBP, CEUs, tx/interventions/philosophy, CI credentials, CI participation, onboarding requirements
- Workflow: supervision, productivity, documentation, billing, culture, role of PT, direct access
- Quality of student: readiness, performance, assessment, site selection, school requirements, affective behaviors

• Discuss strategies/solutions for decreasing unwarranted variation.
• How can academic-clinic partnerships assist with variation?
• How can regional consortia/collaborations assist with variation?
VARIATION WRAP UP

- What strategies or solutions were generated through your discussions?
- How can stronger partnerships help improve variation issues?
- What positive changes can we implement in our schools, clinics and consortia?
CLINICAL EDUCATION CAPACITY

Results from survey
Break-out discussions
SUPPLY AND DEMAND

Select the option that best describes capacity in your consortium's region

- Supply exceeds demand (45.5%)
- Supply meets demand (54.5%)
- Demand exceeds supply (0%)

22 responses
GEOGRAPHIC DISTRIBUTION OF CAPACITY RESPONSES
Capacity for clinical education placements is sufficient for the following practice settings in consortium region (check all that apply). Note: this question is specifically looking for capacity in the region and not for the programs’ ability to secure sufficient resources within or outside the region.

22 responses

- Acute care: -2 (9.1%)
- Inpatient rehab: -2 (9.1%)
- SNF/ECF: 9 (40.9%)
- Outpatient Hos: 21 (95.5%)
- Private practice: 21 (95.5%)
- Pediatrics: -5 (22.7%)
- Specialty prac: 6 (27.3%)
Capacity for clinical education placements is insufficient/limited for the following practice settings in consortium region (check all that apply). Note: this question is specifically looking for capacity in the region and not for the programs' ability to secure sufficient resources within or outside the region.

20 responses

- Acute Care: 19 (95%)
- Inpatient Rehab: 20 (100%)
- SNF/ECF: 10 (50%)
- Outpatient-Hospital: 0 (0%)
- Private Practice: 0 (0%)
- Pediatrics: 11 (55%)
- Specialty Practice: 12 (60%)
COMMENTS RELATED TO CAPACITY FROM SURVEY
COLLABORATIONS TO ADDRESS CAPACITY

- Site sharing
- Open slots shared/traded
- Schedule collaboratively
- Education of clinics/clinicians on:
  - Effects of contracting/letter of intent with new programs
  - CI education on hosting early level students
- PT program and PT/PTA program collaboration of DCE’s for 2:1 placement of various level students
ISSUES AFFECTING CAPACITY
Academic program density

CAPACITY POLLING

- “Academic” clinical educators
  - https://play.kahoot.it/#/k/b8c8077f-53e9-4826-aea1-ff40c89dfb0d

- “Clinical” clinical educators
  - https://play.kahoot.it/#/k/c73dcadf-cd0e-4936-9677-74189f4d624e
"ACADEMIC" CLINICAL EDUCATOR PERCEPTIONS OF ACADEMIC PROGRAM DENSITY IN THEIR REGION

POLL RESPONSES

PT PROGRAM DENSITY

- Greater than 1 academic program within 10 miles
- 1 academic program within 10 miles
- Closest academic program 10-25 miles away
- Closest academic institution >25 miles away

PT/PTA PROGRAM DENSITY

ACAPT
NATIONAL CONSORTIUM OF CLINICAL EDUCATORS
"CLINICAL" CLINICAL EDUCATOR PERCEPTIONS OF ACADEMIC PROGRAM DENSITY IN THEIR REGION

POLL RESPONSES

PT PROGRAM DENSITY

- Greater than 1 academic program w/i 10 miles
- 1 academic program w/i 10 miles
- Closest academic program 10-25 miles away
- Closest academic institution >25 miles away

PT/PTA PROGRAM DENSITY
“ACADEMIC” CLINICAL EDUCATOR PERCEPTIONS OF CLINIC SITE/HEALTHCARE DENSITY IN THEIR REGION

POLL RESPONSES

- High healthcare density
- Moderate healthcare density
- Sparse healthcare density
“CLINICAL” CLINICAL EDUCATOR PERCEPTIONS OF CLINIC SITE/HEALTHCARE DENSITY IN THEIR REGION

POLL RESPONSES
CAPACITY BREAK OUT DISCUSSIONS
Discussion #1: Are capacity perceptions reality?

- Is there a lack of capacity in total or only in certain areas of practices or geographical locations?
- How could the current number of sites be utilized to maximize their effectiveness in meeting your school’s or region’s needs?
- What system is used in your area to maximize capacity?
- If in reality demand does exceed supply, what strategies do you as a school and consortium use to meet your current needs?
CAPACITY BREAK OUT DISCUSSIONS
Discussion #2: How can you increase capacity in your region?

- What current strategies are being used to increase overall capacity and specific capacity in deficient areas?
- Have you modified or changed any of your processes?
- Have there been any changes in program curricula or regional strategies to help address capacity problems?
- Are new strategies needed? Share ideas.
CAPACITY BREAK OUT DISCUSSIONS
Discussion #3: How does PTA education and new PT/PTA programs impact capacity in your region?

- What strategies have you used to meet the needs of both PT and PTA education in your region?
- How can PT or PTA curricula be modified to assist with capacity issues?
- How can your consortium or school collaborate and communicate with new programs to maximize capacity?
CAPACITY WRAP UP

- What solutions were generated through your discussions?
- How can stronger partnerships help with capacity issues?
- What were common themes in your discussions?
- What positive changes can we implement in our schools, clinics and consortia?
SUMMARY AND TAKE-HOME
SUMMARIZING THIS SESSION

- What will you take home with you?
- What resources do you need?
BACK TO THE SUMMIT: OCTOBER 2014

7 Position Papers: Themes (Thank you OH/KY!!)

- Partnership
- Roles and Responsibilities
- Quality
- Assessment
- Administration of Clinical Education
- Research
- Challenges

https://docs.wixstatic.com/ugd/ee4e8e_cb5b2a20b61c48078c17a4fc79376997.pdf
https://www.okptce.com/position-papers-and-webinars
BACK TO THE SUMMIT:
Recommendations overview

- Systemic and interconnected approach to strengthening clinical education
- “Culture of teaching and learning will be the basis of strong partnerships and quality curricular experiences that achieve student readiness”

http://www.acapt.org/documents/reports
BACK TO THE SUMMIT:
Harmonization recommendations

- **Culture of Teaching and Learning**: shared responsibility, common language
- **Partnerships**: CE partnerships, CCCEs as education leaders, site recognition
- **Curricular Experiences**: clinical curricula, ICE, criteria for exiting curriculum
- **Student Readiness**: readiness to enter/progress, student competencies
BACK TO THE SUMMIT:
Innovation recommendations

- **Partnerships**: culture of shared responsibility, collaboration through networks

- **Curricular Experiences**: terminal internship, community-centered physical therapy services
BEST PRACTICES IN CLINICAL EDUCATION TASK FORCE

- Recommendation 1: Preparation for practice
- Recommendation 2: Standardization of clinical education curriculum
- Recommendation 3: Partnerships
- Recommendation 4: Data Management
- Recommendation 5: Education research agenda includes clin ed
WHAT’S NEXT?

Where do you see regional consortia fitting into this picture?

What resources do you need to accomplish goals?

Next ELC: what’s our next step?
HAVE A GREAT CONFERENCE! 😊